HOUSE BILL No. 1152

DIGEST OF INTRODUCED BILL

Citations Affected: IC 27-8; IC 27-13.

Synopsis: Insurance matters. Prohibits an insurer from submitting a recoupment claim to a health care provider because of overpayment by the insurer later than one year after the provider filed the original claim with the insurer. Requires an insurer or a health maintenance organization, upon request, to provide a provider with the insurer's or health maintenance organization's reimbursement fee schedule for the services provided by the provider. Requires the department of insurance to prescribe a credentialing form to be completed by providers applying for credentialing by an insurer or a health maintenance organization. Requires an insurer or a health maintenance organization to: (1) use the form prescribed by the department; (2) notify a provider about any deficiencies or missing information in the provider's application within seven business days after receiving the application; and (3) update the provider on the status of the application within 45 days after receiving the application and every 30 days thereafter until a final determination is made on the provider's application.

Effective: July 1, 2002.

Pelath

January 9, 2002, read first time and referred to Committee on Insurance, Corporations and Small Business.

Introduced

Second Regular Session 112th General Assembly (2002)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2001 General Assembly.

HOUSE BILL No. 1152

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-8-5.7-9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: **Sec. 9. (a) An insurer may not, more than one (1) year after the date on which the claim was filed by the provider, submit to a provider a claim that has been adjusted by the insurer because of an overpayment by the insurer to the provider.**

(b) Subsection (a) does not apply if a provider agrees, on a claim by claim basis, to accept a claim more than one (1) year after the date on which the claim was filed by the provider.

SECTION 2. IC 27-8-11-3, AS AMENDED BY P.L.1-1999, SECTION 59, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 3. (a) An insurer may:

(1) enter into agreements with providers relating to terms and conditions of reimbursement for health care services that may be rendered to insureds of the insurer, including agreements relating to the amounts to be charged the insured for services rendered or the terms and conditions for activities intended to reduce

inappropriate care;

(2) issue or administer policies in this state that include incentives for the insured to utilize the services of a provider that has entered into an agreement with the insurer under subdivision (1); and

(3) issue or administer policies in this state that provide for reimbursement for expenses of health care services only if the services have been rendered by a provider that has entered into an agreement with the insurer under subdivision (1).

(b) Before entering into any agreement under subsection (a)(1), an insurer shall establish terms and conditions that must be met by providers wishing to enter into an agreement with the insurer under subsection (a)(1). These terms and conditions may not discriminate unreasonably against or among providers. For the purposes of this subsection, neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiation nor price differences among other providers in different geographical areas or different specialties constitutes unreasonable discrimination. Upon request by a provider seeking to enter into an agreement with an insurer under subsection (a)(1), the insurer shall make available to the provider **the following:**

(1) A written statement of the terms and conditions that must be met by providers wishing to enter into an agreement with the insurer under subsection (a)(1).

(2) A list setting forth the amount paid by the insurer for each health care service for which:

(A) the insurer provides reimbursement; and

(B) the provider provides services.

(c) No hospital, physician, pharmacist, or other provider designated in IC 27-8-6-1 willing to meet the terms and conditions of agreements described in this section may be denied the right to enter into an agreement under subsection (a)(1). When an insurer denies a provider the right to enter into an agreement with the insurer under subsection (a)(1) on the grounds that the provider does not satisfy the terms and conditions established by the insurer for providers entering into agreements with the insurer, the insurer shall provide the provider with a written notice that:

(1) explains the basis of the insurer's denial; and

(2) states the specific terms and conditions that the provider, in the opinion of the insurer, does not satisfy.

(d) In no event may an insurer deny or limit reimbursement to an insured under this chapter on the grounds that the insured was not referred to the provider by a person acting on behalf of or under an

agreement with the insurer.

(e) No cause of action shall arise against any person or insurer for:

(1) disclosing information as required by this section; or

(2) the subsequent use of the information by unauthorized individuals.

Nor shall such a cause of action arise against any person or provider for furnishing personal or privileged information to an insurer. However, this subsection provides no immunity for disclosing or furnishing false information with malice or willful intent to injure any person, provider, or insurer.

(f) Nothing in this chapter abrogates the privileges and immunities established in IC 34-30-15 (or IC 34-4-12.6 before its repeal).

SECTION 3. IC 27-8-11-7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: **Sec. 7. (a) As used in this section, "credentialing" means a determination, based on criteria established by the insurer, whether a provider is eligible, under an agreement with the insurer, to provide health care services to the insurer's insured in return for reimbursement by the insurer.**

(b) The department shall prescribe a form to be completed by a provider who is applying for credentialing by an insurer.

(c) A provider applying for credentialing by an insurer must complete the credentialing form prescribed by the department.

(d) An insurer shall use the credentialing form prescribed by the department under subsection (b) in determining whether a provider should be credentialed by the insurer.

(e) An insurer shall notify a provider of any deficiency in or information missing from the provider's application not later than seven (7) business days after the insurer receives the provider's application for credentialing.

(f) An insurer shall update a provider on the status of the provider's application not later than forty-five (45) days after the insurer receives the provider's application for credentialing.

(g) After updating a provider under subsection (f), the insurer shall continue to update the provider on the status of the provider's application every thirty (30) days until the insurer makes a final determination on the provider's application for credentialing.

SECTION 4. IC 27-13-1-10.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: **Sec. 10.5. "Credentialing" means a determination, based on criteria established by the health maintenance organization, whether a provider is eligible, under an**

agreement with the health maintenance organization, to provide health care services to the health maintenance organization's enrollees in return for reimbursement by the health maintenance organization.

SECTION 5. IC 27-13-42 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]:

Chapter 42. Provider Agreements

Sec. 1. This chapter applies to a health maintenance organization that provides basic health care services.

Sec. 2. Upon request by a provider seeking to enter into an agreement with a health maintenance organization, a health maintenance organization shall provide the provider with a list setting forth the amount paid by the health maintenance organization for each health care service for which:

(1) the health maintenance organization provides coverage; and

(2) the provider provides services.

Sec. 3. (a) The department shall prescribe a form to be completed by a provider who is applying for credentialing by a health maintenance organization.

(b) A provider applying for credentialing by a health maintenance organization must complete the credentialing form prescribed by the department.

(c) A health maintenance organization shall use the credentialing form prescribed by the department under subsection (a) in determining whether a provider should be credentialed by the health maintenance organization.

(d) A health maintenance organization shall notify a provider of any deficiency in or information missing from the provider's application not later than seven (7) business days after the health maintenance organization receives the provider's application for credentialing.

(e) A health maintenance organization shall update a provider on the status of the provider's application not later than forty-five (45) days after the health maintenance organization receives the provider's application for credentialing.

(f) After updating a provider under subsection (e), the health maintenance organization shall continue to update the provider on the status of the provider's application every thirty (30) days until the health maintenance organization makes a final determination on the provider's application for credentialing.